JCAHO Survey
Munson Army Health Center
Day One – April 13, 2004

Dr. Dann, Ludwig and Mims, JCAHO Surveyors all arrived at 0730 (MK's notes)

Introduction – 5 minutes

Summary – New Process – Education/Consultation
"No Score"

Fort Drum – issues – no shows for appointments selected, so using different process this time. At Fort Drum they proceeded to do open records due to the no shows they kept pulling in clinics. Surveyor commented that he would like to talk with patients – if they give their approval.

Want to know what the staff do on a daily basis. Do not want to know about policies. Will not ask about policies.

Final close out tomorrow afternoon for Behavioral Health piece since he is only here for 2 days.

Final report goes to JCAHO the day they leave. We should have access to on JAYCO website in 3-5 days later.

Evidence of standards compliance will be needed if they identify any shortcomings before they will re-issue accreditation. Instructions will be on JAYCO website on how to supply info to show we are now compliant with standards. Once these are approved we are good to go. Until that time our current accreditation will stand.

PFA: Information/Assessment & Care of Patient/Patient Safety/Communication
These are the ones listed for them to review for our facility, however, they may look at any of the 14.

Clinical Practice Groups

System Tracers they will be looking at are Medication Management, Data Use, Infection Control. Surveyors have chosen to look at these as a group. (We made several changes to survey agenda that was sent after opening conference.)

Took about ten minutes to brief the above.

Ludwig was listed as leader, however, it appeared that he had deferred leadership to Dr. Dann

---

Commander presented Orientation to facility – lasted about 35-40 minutes (8:10 – 8:50)

Q: What is the Population of the surrounding area that supports the three hospitals you referred to in the immediate area? (40,000 – 20,000)

Administrative surveyor took a lot of notes regarding POD system that was described to him.

MEDBASE asked a few questions about this system and how it was going to be used and would it connect to CHCS II – not today – will in future. Will data transfer from MTF to MTF?

It appeared that we answered most of their questions before they could ask.

Where on Post is care provided?

Gentry
MAHC Building
USDB
Richards-Gebaur Clinic (Marine, Navy, and dependents)

Deployment: Asked us who was deployed currently

1-Family Practice
1 primary – Nurse
1 primary – Corpsman
1 primary– Physician Assistant

With them out, how do we provide care to their patients with POD concept? Spreading out care to other PODS and if no space we ok them to go to network.

POD – they function same

CPT Saunders – talked about POD concept, tour, help manage referrals

---

Asked about Behavioral Health Numbers, were they on the rise due to war?

No major changes.

Also asked if number of substance abuse had gone up?

Psychiatrist – 1 year without.

PI – Sylvia talked about CPG related to behavioral health.

If increase noticed do we have resource for them to address?

a. Asked if records were decentralized with POD concept?
(comment – can cause more problems). Glad we had not done that.

b. Where has MEDBASE been implemented? Just primary care right now.

c. Did several scenarios regarding patient in one POD seen in another and how is info shared? For whatever reason – what are the challenges to provide info from nurse to nurse, doc to doc, etc.

d. Patient assigned Provider D and sees Provider A. How does Provider A get referral? Who is primary? Who signed referral order? Questions like this were asked. Who gets results?

e. How do we address compliance with PS goals or other goals for that matter?
How do you monitor compliance? chart reviews and observation?

f. CPGs – do you use? How many have you implemented? eight implemented
Was one of them hypertension? Sylvia Arvizu, CPG Coordinator talked about these.

Can you track how well they are working with clinical outcomes? Asked what metrics we were using for diabetes. Can you tell how we are compared to other MTFs?

g. Surg – SDS asked us to describe what we did here.

1. Describe what is done here?

ASIII – rarely
23 hour scheduled non-acute and non-emergent.

2. How many a day?
45-50 per month

3. Do we do Endo in addition to regular surgery?

4. Asked who provides Anesthesia? Two CRNAs

h. At end of presentation they all commented on that this was one of the most informative orientation briefs they had ever received. They loved it.

DAY 1 13 April 2004- Morning Wanda's Notes

1. Went to ASC with Dr. Dann and Dr. Thompson- Dr. Thompson was asked and explained about how USDB inmates are taken care of, i.e. control/guards/weapons/handcuffs, infection control issues with the guards in the OR, etc. All questions answered and explained.

2. Reviewed APV and outpatient records on pt who underwent C-scope & EGD today was reviewed (60 yo female). Dr. Dann opted not to talk to family as it was post procedure and pt had been given sedative medication.

a. Dr. Dann reviewed both records and asked about second surgeon's name on Consent. Explained that he has a contractor surgeon who has not done many scopes recently and is being retrained. Asked how conscious sedation is done, who does it and how they are trained. Dr. Thompson, Mrs. Tallman and Mrs. Flanagan appropriately. Asked how scopes work, i.e. who does the procedure, who gives the drugs, how many are in the room and what is there job. On pre-op patients, when are they medicated? **The role of the RN in endoscopy procedures should be monitoring vitals and drug dispensing only.**

b. DNR/Advanced Directives was a big topic. Dr. Dann asked how we know if a patient has these. The pt is asked by PAD and at pre-admission. He was told who the patient can contact if they are interested in Advanced Directives. He stated that **the three essential elements to DNR/Advanced Directives is to have a policy in place, inform the patient of this issue and help the patient obtain them if desired.** If a patient has Advanced Directives they are told that we will not honor them if there is a problem during their surgery. We will stabilize them and transfer them to a civilian hospital. Dr. Dann asked if this statement is documented in the record. None of the personnel spoken to in the ASC could answer this. **Not as a finding, but as a recommendation, Dr. Dann recommended that this statement documenting that the patient is made aware that we will not honor Advanced Directives, and for the patient to sign, should be placed on the Advanced Directives form that is currently in use.**

c. **One problem noted was that the H&P was done 9 March and the procedure was done today.** This will not be a finding, but further checking will be done to see if there is a trend.

d. Mrs. Tallman was asked to walk Dr. Dann through the pre-op procedure step by step. Questions were asked and answered appropriately on interpreters for foreign language patients, what to do if the patient has a pain of 6-7 or higher, how do you verify patient ID and how do you ensure on pre-op that the correct site is being operated on. All answers seemed to meet with approval.

DAY 1 13 April 2004- Afternoon

1. **OPERATING ROOM:**

a. Interviewed MAJ Roehl in Operating Room. Since morning patient had undergone endoscopic procedures, Dr. Dann requested to see the actual Endoscopy room.

b. Scope room was inspected and questions were asked about how the nurses perform the conscious sedation and what equipment is used and why. Question was asked about ASA III patients. MAJ Roehl reported that those were not done here on a routine basis. Generally if they were scheduled, they would be done at one of the local civilian hospitals.

c. Dr. Dann asked about some other equipment in the room. One was an old scope set and the other was an anesthesia machine that was reportedly not working, was broken and was marked DO NOT USE. Some extra equipment is stored in the scope room, but is separated from the actual scope area. It was recommended that any equipment that is not used/broken or missing parts be replaced.

d. Dr. Dann asked how the scopes are cleaned, so SGT Boyd, NCOIC of the OR was brought into the room. She explained in a step by step manner the procedure and equipment used. This included explaining routine checks of the sterilizers for bacterial issues and parameters of the sterilizers when asked how they are checked.

e. After completing the procedure policy in the scope room, they then moved to the actual room where the scopes are cleaned.

f. Dr. Dann inquired as to the procedure if a patient codes while in the scope room and this was explained that the surgeon would change gloves, the nurse would chart and anesthesia would bring their cart (with medications) and the defibrillator from the crash cart.

g. Both OR rooms were inspected and discussed with Dr. Dann, including showing him where guards would stay when an inmate is being operated on (this had been a question from the morning).

h. The crash cart was opened and inspected for outdated medications. MAJ Roehl was asked how/when/what is checked on the crash cart. Also reported who replaces the meds, fluids and tubing. No expired medications were found. MAJ Roehl was asked how quickly Dantrium could be obtained if they ran out of it and needed more. (This was in the malignant hyperthermia cart.) This question was later answered by MAJ Cassidy when he arrived following an appointment. What is in the HM cart is all that is in the facility. The Pharmacy does check these quarterly for outdates and orders more as needed to replace expired ones.

i. The dirty linen/contaminated room was opened and the use of red bags was questioned. MAJ Roehl reported that due to the low (if any) volume of actual regulation medical waste, that the OR does not use them. Dr. Dann reported that was good since majority of the time the waste put in them is not regulated medical waste.

2. **ANESTHESIA:**

a. MAJ Cassidy was then asked about the medications in the anesthesia work room. He was asked who is responsible for the anesthesia drugs, where are they stored when not in use and who refills them. Anesthesia is totally responsible for the drugs, Pharmacy refills and the drug box is stored in a safe in the ASC behind locked doors.

b. When anesthesia gives conscious sedation, they do a complete workup and give more than conscious sedation, such as Prophypholl (sp?). He was asked about the training for conscious sedation and reported that he does the training (slides, hands-on training) then if the person passes then are considered competent to do conscious sedation (this is only RNs and OR nurses)

c. Site verification and patient ID steps were all noted for Dr. Dann when asked.

d. Gas (anesthesia) machines are inspected by the company regularly and each daily.

f. The Narcomed machine noted above in the scope room is not broken, and should be in plastic. It is new and has not been checked out yet to put into service.

g. Question was raised as to how patients are transported in the case of an emergency (in regards to surgical patients in the OR or PACU/ASC). **Need to make sure that there is either a formal agreement or that all providers have admitting privileges at a JCAHO approved hospital.** The different steps were explained in detail by Dr. Thompson and MAJ Cassidy.

3. **PACU:** The PACU was again visited as a post-surgical visit on the scope patient from the morning review.

a. Mrs. Flanagan went over step by step what is done as soon as the patient is ready to return from the OR up until the time that patient is discharged home.

b. Upon review of the chart two items noted missing were the ASA class was on the orders, but not circled on the nursing sheet. The other was that there was no note stating who the responsible person is at the time of discharge for the patient. This was inadvertently left off of the nursing note, but the husband had signed the discharge instructions sheet. **Recommendation was made that a system needs to equate and event or format with consistent documentation. A line will be added to the PACU sheet stated that "Patient was discharged and accompanied by (whoever) (person's name)….. This will ensure double protection when the patient is discharged.**

c. Question was asked if the patient must be seen by provider prior to discharge. Answer was "No, as long as they meet the established criteria."

d. Mrs. Flanagan was asked if they take verbal orders. She reported "No, not in the PACU because the provider is sitting there and there is no need for a verbal order."

e. A list of unauthorized abbreviations was next asked for. The most recent list was provided. The use of these abbreviations needs to be tracked and Dr. Dann stated (when he found out who may be the one doing this- Becky Jordan) he may have to visit her also. Dr. Thompson reported that the only time they unauthorized abbreviations might be used is if there is a special drug request which is handwritten, but that they are avoiding the use of the abbreviations. All other medications are ordered in CHCS. **Upon review of the scope chart from the morning, on the preprinted orders there is an order for <u>Versed 10 IV. This does not have what the 10 is and should be changed.</u>**

JCAHO Survey
Munson Army Health Center
Day One – 13 April 2004

CPT Henderson's Notes

13 April 2003

EOC and Statement of Conditions 1030am

Went through book on request for funds.
Q: Do you clean ducts on an ongoing basis? Regarding a request for funds for cleaning all ducts.

Q: Tell me your schedule. What are the laws governing your systematic approach to cleaning ducts?

Need report on last cleaning of each area.

What changes do you make in schedule when doing major construction?

Went through the results of the CHPPM surveys.

Looked at Safety Management Plan.

Talked about seven EOC Management Plans
- How written
- Approval process
- Implementation
- Review process

Who sits on EOC Committee?

What is biggest challenge in security management for this post?

"I'm a new file clerk and assigned to the prison, where do I get my security training?"

Needs minutes that show where the most recent set of management plans were approved.

Needs a couple of documents – Number of Anesthesia Machines.
- Wants records on the anesthesia machines and on endoscopy unit (monitor)
- Looking at critical fail/safe machines
- Record on pulse oximeters

Constructive criticism – EOC has large membership

Patient Safety Interview 1100

Impressed with having a person (Becky) assigned to get through seven patient safety goals.

What did you do from an ambulatory care standpoint to get on board with new goals?

Went through goals – What have you done to improve patient ID accuracy?
Use name, SSN, birth date, and photo ID

Wants to see MEDCOM form for "Time Out" prior to surgical procedure.

How do you monitor that the dermatologist that comes here for half a day once a month to follow procedures?

What was the challenge in implementing with IB (Time Out)?

Do you have a summary sheet showing how you are complying with patient safety goals?

Verbal order read back.

Find chart where surgeon gave CRNA a verbal order or vise versa.

2B – abbreviations – wants to see the local directive (minutes).

Research blood pressure machine with alarm and pulse oximeter – does it have an alarm?

What did you do to beef up your infection control measures?

What do you think are the one or two best things you have done to implement the goals?

"If you don't measure outcomes it isn't any good."

Need to see chart – trauma then sent out

Gentry Clinic Tracer Methodology

Show me a record and tell me about patient.

Tell me about MEDBASE.

Enlisted soldier – healthy – here two years – would you have seen him?
No unless due a physical
How do you feel about that from a PM standpoint?

Chart review
Why was he here?

Is chart availability a problem?
What will you do to fix it?
Adequate information to referred doctor vs. lost chart.
Out of 100 referrals, how many were delayed in getting back or didn't get back?
Trended by provider?
In the past 100 patients seen, how many did not have charts?
Answer: 20% - 15% can be seen in MEDBASE/CHCS.
Of them, how many made you alter your normal operating procedure?
Answer: None
Should do a random check.

Patient Rights and Ethics and Continuum of Care

What process is in place for when doctors deploy on short notice? Who does follow-up with patient?

Suggestion – Monitor availability of medical records
– Date/time stamp all entries on medical records.

Have policies been updated to establish parameters during transition from handwritten to electronic medical records?

Recommendation – establish parameters for what should and should not be in records (constructive criticism).

PAD – how many records unavailable to pull?

Found clinical inconsistencies in record of Patient.

How does peer review differ between contractors, GS and military providers?
Answer: no difference

Who does peer review?

Charts may not be a random sample due to the person being reviewed selecting the charts that their "peer" will review.

1. Peer review (on site by supervising physician)
2. By Medical Records personnel (medical records review, administrative review)
3. CPGs monitoring (targeted review)

Need to look at a credentials file

Re-privileging process – how does clinical peer review differ from initial peer review to initially grant privileges?

Results

No date/time on note.
No record of procedure in system.

Suggestion

Need systematic approach to bridge gap between paper and electronic systems.

Munson Army Health Center
Fort Leavenworth, KS 66027
13 Apr 04
Behavioral Health Care JCAHO Survey

Surveyor: Mr Mims **Scribe: CPT Lara**

Morning Session
Surveyor asked when last time JCAHO inspected CMH. Ms McLilly said about 3yrs ago. Surveyor then went through the process of the new JCAHO inspection process and what it would entail. Surveyor stressed the importance of uniformity and stated that all areas of CMH should be treated the same.

Surveyor then asked open-ended question of "What does uniformity mean to you?" Ms McLilly responded with all CMH now located in MAHC and having all the services on one floor, open communication between staff members, the use of tracking document DD Form 2161, and by having case review committee meetings and staff meetings.

Surveyor wanted to know how patient information got into the medical record. CPT Atkinson responded by computer interface, hard copies and a 600 overprint.

Surveyor questioned how patient information or records could be accessed after duty hours such as on call doctor or provider downtown. Ms McLilly stated that there is always a CMH staff on call plus on call doctor would have access to 600 overprints.

Surveyor stressed importance of who is involved with the treatment plan, how does communication take place between different services of CMH, who can diagnosis, prescribe, etc. In addition stressed importance of having one chart for all three services of CMH(Family advocacy, ASAP, Psych).

SGT Hanson explained that due to regulations that there isn't one chart, but with MEDBASE and other changes that the Army is going in the direction of one chart, but that Mr Mims would not find that in the section on his visit. Explained that many patients are being followed by more that one service of CMH so there would be more than one chart. Mr Mims realized this, but stressed that streamlining must take place and that need to incorporate all services into one chart.

Surveyor was very big on cross checking and used this term frequently such as are the different services in CMH crosschecking with each other to make sure patient's don't get missed, crosschecking with doctors, nurses and social workers.

Surveyor suggested an excellent CQI or PCDA project would be to incorporate all the different services of CMH into one chart and develop a comprehensive psychosocial assessment so that everything could be in one chart. Also, need to develop an integrated summary form. Stated these were only suggestions, but needed to be thought about.

Surveyor again brought up who can prescribe care? Who is privileged? Are the social workers credentialed by MAHC to prescribe care in the alcohol treatment program? Who is authorized by the commander to sign off on the chemical dependency treatment plans. Assumption is MD is only one that can do this. Terminology for diagnosis for treatment plan. Prescription for care is treatment plan according to the surveyor. Surveyor stated credentialing has to be very specific and process has to be exact. Surveyor wanted to know if a MD takes part in group planning/meetings.

Ms Husted stated yes an MD does take part.

Surveyor then wanted to know who could sign off on the prescription of care. CPT Atkinson replied that either he, an MD or DCCS does.

Surveyor wanted to know who is ultimately responsible for signing off on the treatment plan? He feels that it has to be a MD or credentialed provider.

It was explained to the surveyor the credentialing process by CPT Atkinson. Surveyor will meet with Edith Cotton at 0845 14 Apr 04 to brief surveyor on credentialing and competency of providers.

Surveyor then asked if this was not discussed in the last JCAHO survey and answer by all staff present was no.

Ms McLilly then explained that the new credentialing process was much more strict and specific and that MEDCOM looks at providers/staff in CMH on an individual basis. Surveyor said he understood that, but said that department can define competencies, but the command still has to sign off on it.

Surveyor then looked at charts to see patient process from intake to outtake. Surveyor asked if the charts were the same for chemical and behavioral.

CPT Atkinson then responded that no they are not the same. Surveyor then said it is very difficult to follow, as there are basically three different ways to follow care.

Chart looked a for the next section: both FAP and Psych charts were looked at.

Surveyor wanted to know who referred by. Answer was mother. Surveyor wanted to know how Ms Husted remained competent. Answer given by Ms Husted was CEU's, training, in services.

Ms Meath they explained her role in the intake process. Surveyor stated all staff involved with patient care should write a note.

Surveyor did not like all the abbreviations used by CMH. Requested approved abbreviations for MAHC. Again the usage of crosswalk came up such, as you need to crosswalk your use of abbreviations with the organization, need to crosswalk with FAP and Psyche.

Surveyor wanted to know if all cases aren't routinely presented to an MD. Answer was all cases are not presented.

The surveyor did not like the way charting was done in this particular chart. Said charting was somewhat vague Surveyor wanted medicine doctors to be included in the chart.

Surveyor asked if treatment plan on chart was standardized? Ms Husted responded no.

Surveyor really liked the Case Review Committee Presentation and Summary found on the chart and said this is what he was looking for when he talked about an integrated summary from all the different sections of CMH. Stated this MEDCOM form 743-I is very, very close to an integrated summary.

Ms Husted then explained that any case going before the CRC has to be reviewed by a doctor.

Dr Cleveland was then brought in to discuss the above mentioned chart. Surveyor wanted to know how the diagnosis of depression get placed into the chart. Dr Cleveland responded by a DA Form 2161.

Surveyor wanted to know who is ultimately responsible for making decision to place a patient in the hospital. Dr Cleveland responded by saying it varies, but in this particular case I am. She then talked surveyor through process of admitting patient to the hospital.

Surveyor brought up prescription of care and said it is very important and wanted again to know who could sign off on it. Who has that authority. Again brought up who can do what? Organization has to decide who can do what. Competency was explained to him by staff. Surveyor also wanted to know who can rule out.

Surveyor wanted to know the role of the psych nurse practitioner. This was explained by Ms McLilly. Surveyor wants to see psych nurse practitioner credentials. Surveyor brought up the integrated plan of care again and integrated treatment plan. Stated need to be more specific in charting.

Afternoon Sessions
Surveyor wanted to know if the psych nurse practitioner can prescribe medications. Answer by CPT Atkinson was yes she can. Surveyor then wanted to know what types if detox was done here. Ms McLilly explained the policy for the Army and MAHC.

Surveyor again brought up who can sign off on the treatment plan.

Chart looked a for the next section: both ASAP and medical charts were looked at.

Ms Sigmon talked surveyor through process of intake of ASAP patients. Surveyor wanted to know if a nutritional status, pain, were assessed and documented. Answer was no, but developing a form that will take these into consideration. Nutrional status is and a pain assessment form is being developed.

Surveyor was very concerned about standing orders. Big issue arose over CHCS: clinician entering labs into computer(who does this?, who is authorized to do this?), could not see signature of ordering doctor on the chart for labs, and not being able to see proof that doctor saw the results on the computer.

Surveyor then touched upon the integrated care plan again or integrated summary. Felt integrated summary was being done too soon on ASAP patients and need to wait a couple of days. Instead wanted to staff to do a brief summary and do the integrated summary a few days later.

Surveyor then questioned CPT Bevington, company commander, HHC 705th. CPT Bevingtion was very pleased with care provided his soldier's.

Surveyor said that soldier's have to be reviewed if transferring from post to post and has to be reviewed by a MD. Again brought up: who can prescribe?, who can do what?, and who can diagnosis?

Surveyor three big questions: How does MAHC authenticate our computer generated orders and records? Where does the doctors signature appear on the computer?, and would this hold up in a court of law?

Surveyor and Ms McLilly discussed spirituality issues briefly.

Surveyor closed by saying JCAHO does not require a written integrated summary, but still have to have a process. Stated the Bhatty chart had a great integrated summary.

Staff Interviewed: Ms McLilly, CPT Atkinson, Dr Cleveland, Ms Meath, Ms Husted, Ms Sigmon, SGT Hanso.

Outside People Interviewed: CPT Bevington, HHC 705th Company commander

Looked at 8 charts.

DAY 2 – MORNING BRIEF

Dr Dann

Commented that he had a great day and was really impressed with facility and staff.
He completed on patient tracer that brought him through endoscopy, OR, pre-admission process, surgery experience overall and PACU that led to quite a few discussions with various staff members. He was able to review a lot of our systems. He did find one H & P that was over 30 days old and he commented on typographically error on standing order sheet that does not designate amount of medication to be given, i.e., 20 what? meq or mg, he thought that would be an easy fix. He said he would be pulling more records to see if he noticed a trend on H & P.

He looked at crash carts and process for checking. Very happy with that process.

Mr. Ludwig

In morning he met with EOC and went over statement of conditions and seven environment of care plans. He was very happy with statement of conditions and signed off on those. Also very happy with environment of care plans. Thought our POC for this area was very knowledgeable. He will be doing life safety tour tomorrow.

Also talked with Patient Safety Manager – current RN in position and also Pharm D who stood up our program initially. Very happy with their interview – commented he would like to steal them. Thought we did an excellent job of implementing and enforcing the applicable national safety goals.

Afternoon did a patient tracer. Noticed a problem with us having parts of record in both hard copy and in computer system (MEDBASE) we are currently implementing. Commented on communication problems that result from this type of situation. Liked open access system, but commented that this also leads to problems with follow-ups and no shows sometimes. He had a problem with one record he reviewed. He is going to have more records pulled to review a possible issue with patients being seen outside their POD and communication that occurs when this happens.

Mr. Mims

Commented that staff was very knowledgeable with much experience between them all.
He did several tracers – commented on structural issues he thought we had due to part computerized and part hard copy records. He commented that it appeared that coordination between the different programs appeared to be occurring, but that documentation was lacking in charts to support this. Evidence of collaboration is how he referred to this – PC.4.40.

He thought that we had too many different treatment plans. He thought we should have one record not a different record for each service. Wanted to know how they addressed medical findings outside their scope of care. Commented again that treatment plans do not include what was being done in other programs. Also that they did not address all problems/issues identified.

Said if we do not address an issue, we need to say why – comment that it was deferred to a later date, etc.

Didn't like method of ordering lab tests in computer. Wanted to know who approved and who reviewed these tests. We are going to have him sit with provider who does this sometime this morning and explain the process to him.

Didn't like the fact that we had several people who could write treatments plans. Felt we should have one individual who approved all plans. Commented that clinical outcomes need to be monitored on integration of plans in CMH.

Does not like all the abbreviations that we allow. Thought it was way too many – including those found in AR-40-66. Thought we should do a chart audit to see if all abbreviations being used were approved ones.

DATE: 14 April 2004 **SURVEYOR: Dr. Dann**

SCRIBE: Mrs. Sanborn **AREA: RGBC**

1. Introduced to Bobbie Love, Receptionist. Asked what is the process for when patients check in. They check military ID, address/phone number, and check for appointment in the computer. This is done each time the patient has an appointment. Do they sign in on anything? No, this is done only through the computer by the staff. Are medical issues discussed at the reception desk with the patient? No, that's done by the screener in the screening room. Once patient checks it their record is turned so that the patient name is not identifiable and is left on the desk until picked up by the screener to take the patient in for vitals, etc. Ms. Love was asked if the record is left there unattended. She stated, No, that she stays at the desk until the record is picked up by the screener and does not leave the desk when there is a record out on top of the desk.

2. Screening room (there is only one) was toured and bulletin board was looked at to see what information was there.

3. Janet Smith was met next. She works in the lab. She was asked what happens to labs (blood/urine, etc.) after being drawn. They are kept in the refrigerator in the drawing room until the courier comes from MAHC that same day and takes them to MAHC for evaluation. Results generally return the next day via CHCS. UA dipsticks are done at RGBC and not sent to MACH. NO HCGs are performed there without being sent to MACH. _____(could not hear the name) certificates are required. If a specimen is not picked up the same day, it is then put in the freezer in the procedure room, which is locked.

a. Was asked about her training/orientation since she is new to the facility. She explained in detail the orientation she has received, to include walk thru of the section, review of SOPs, CBO training, IV recertification, working at various areas of MAHC to be trained in that area.

b. What type of safety equipment do you use when drawing blood? Gloves, goggles, safety needles.

c. What is kept in the refrigerator? Blood draws, UAs, and controls. Question was then asked about the manufacturer's recommendations on temperature that, for example, controls are to be kept at. Need to determine manufacturer's recommendations and ensure that temperature is kept at that level. Current temperature was checked to see if it was staying steady. Asked to see documentation that the temperature is monitored routinely. Is there emergency power to the refrigerator? No. How would you know if there was a power outage? **Suggestion is to get an analog clock and plug it into the same wall outlet that the refrigerator is plugged into. This would help to determine if there was a power outage or if the compressor was failing. (Would be able to tell from the clock's ability to keep time.)**

4. Immunization/Procedure Room was then inspected with Mr. Lovett. The refrigerator was checked there also. It has three different temperature checks, including a 24-hour monitor in the refrigerator portion and a "penny in ice" in the freezer section. Per Dr. Dann, the penny could be a good way of determining if there is a problem with the temperature and is something JCAHO

has always recommended. However, they have found that if there is a fluctuance in 24 hours, the penny's position (melting of ice) may not be changed enough to really tell for certain. **Suggestion was to monitor the freezer portion by some other means as well. A clock, like above, could be used or purchase a probe that can be placed in the door/freezer to ensure that there is no fluctuance of temperature. Again, even if there is no power outage, it could be a compressor issue.**

a. The AED, ERB, O2 and calling 9-1-1 are all used for emergencies. There is also the first responders close by that would be there within a couple of minutes. Asked how the ERB is monitored and checked. Was shown the check list from both RGBC and MAHC. ERB was opened and inspected. **Noted that the high concentration Epinephrine (I believe 1:1000) was very well labeled.**

b. Asked what kind of procedures are performed in the room. Minors only, NO SEDATION GIVEN.

5. Asked if they treat kids and was answered that yes, they treat newborns and up.

6. Equipment supply room was inspected. Just outside of this room, the fire evacuation scheme and the fire extinguisher were both also inspected, to include opening the door to the fire extinguisher and looking at the tag.

7. The dirty utility room was inspected and Dr. Dann was told that this was basically for pre-cleaning. The equipment is then sent to MAHC for sterilization and repacking. He asked about the automatic soap/water dispensers and Mr. Delano reported that we only have those in the lab at MAHC.

8. Dr. Dann wanted to look inside the housekeeping closet, but it was locked and Mr. Lovett nor his staff have a key. It was explained that the contractor was having a problem with equipment being stolen at many of the contractor's sites, so kept the door locked. After discussion, it was determined that there is no container that has a hose which would siphon dirty water back into the system in that closet and that Mr. Lovett does have a copy of the MSDS for all material in that closet in case of emergency.

9. One exam room was inspected and did have a pain scale in site, chaperone available if patient requests (all of the medical staff are female, but if someone specifically requests one it is available), and childproof cabinets.

10. An administrative supply room was inspected and it was noted that there was the 18" distance from the fire sprinkler to the top shelf/box. This was noted and commented on by Dr. Dann.

11. The Asthma Treatment/Isolation/Education Room was next. Question was asked when the room is cleaned and it was reported that it is cleaned after each patient.

12. There is a USN Corpsman that works there also and Dr. Thompson reported on her training. The Corpsman was on the phone and unable to be interviewed.

13. Medication Room was checked. When medications are ordered it takes about a week to get them from MAHC. The courier brings pre-packaged medications. There are NO CONTROLLED DRUGS and NO SAMPLES. These were both asked about.

14. Next was the Records Room. Mr. Lovett was asked about the stack of records and reported that they were waiting to be filed. The area is authorized access, via code, only. At this time there are no computerized records, such as MEDBASE.

15. Two records of patients seen today by Dr. Winegarner were reviewed with her present. One did not have the pain level noted on the SF 600 by the screener. Patient was being seen for sinusitis. She puts the codes for each diagnosis and her initials (when she has put the orders (lab or meds)) into the computer. This was not yet done on the first patient, but was on the second chart. This is her own system for ensuring that she has completed the record. Master problem list was also reviewed on both charts.

a. One problem noted was on the sinusitis patient. The patient was to have Amoxicillin 20 mg. It was difficult to read and interpret the "mg" as milligram and not something else. Provider was reminded about using abbreviations and if writing them, to be sure that they are legible.

16. One record of a patient seen by Judy Klingsmith was reviewed with her present. Patient was seen for a refill of medication, but it was noted that over a period of time he seem to have borderline increase of his blood pressure. Patient's parents both are hypertensive and his grandfather had an MI at an early age. HTN is not officially labeled as a diagnosis yet so will not be put on the Master Problem List yet. Dr. Dann asked what the plan was and this was explained as to RTC for the next couple of weeks and have routine BP checks (can even be done elsewhere, but is to bring documentation) and labs were ordered today. Was asked what the turn around time is for labs and was told it is next day.

a. She was also asked about tobacco cessation as the above patient is also a smoker. Currently, due to the recent turnover in personnel, there is only 1 to 1 training being done by the provider. The NP will be trained and there is the possibility of the having the Tobacco Cessation class meet at RGBC at some time in the future. The outcome of this training (either one) is most likely done through the CPG.

b. She was also asked about how the referral process works. All consults (for referral to MAHC or network providers) are put into CHCS thru Tricare who contact the patient with their appointment. If the provider or patient desires a specific network provider that is specified on the consult in the computer. How efficient is it in getting results back from network providers? Research Medical Center has been the main referral point and so they are very good at getting the results back to RGBC within 2-3 days of the patient's appointment. Some of the other providers RGBC deals with are improving and some are new to the referral system from RGBC. Overall, RGBC staff are satisfied with the timeliness of getting the results back.

JCAHO Survey
Munson Army Health Center
Day Two – 14 April 2004

CPT Henderson's Notes

USDB

Q: How are you notified that an inmate needs an appointment?

Q: Do medically qualified personnel screen the patient?

Q: Do you ever go to the inmate's cell to see patients?

Q: How many patients in SHU?

Q: What is the highest level of medical training that personnel have to go see patients in cells?

Need 2 records – last week
1 – patient was fine
1 – provider needed to see patient

dressing change – medic
screened by medic and then seen by provider

*Need "cradle to grave" hazardous waste disposal documentation.

Q: How often are emergency response boxes swapped out?

Pharmacy – will talk about red tabs locking pharm kits (emergency response kits)

Q: If someone coded, how far do you go in resuscitation efforts?

SUGGESTION: May want to tag key ring – can't do it due to DB regulations.

Q: What are you parameters for what you can and can't do?

*Wants to see LaCroix's credentials folder.

Q: Do you have your own generator in the prison? (Why no red plugs?)

Q: Asked for MSDS for iodine.

SUGGESTION: Make copies and place in room.

*Talk to person who oversees Rad Suite at DB – wants to see logs for apron checks.

Very interested in why there are no emergency power plugs.

Q: Where do you store infectious waste?
No sticker on door indicated hazardous waste stored in there. Could be finding but won't be if we have sticker on door immediately.

Q: Who keeps the PT area clean and orderly?
Needs to talk to CPT Gerber

Q: Who cleans hydroculator etc?

*Shatter proof fluorescent light bulbs? Must find out – MSG Bradley

Q: Who draws labs? Who runs the tests?

* Need record on insulin dependent diabetic.

Q: Why do you keep meds in fridge in lab?

Q: Do you have any patients on meds that need to be injected regularly?
A: No.

Q: Process for inmate to get glasses?

Likes the way we check in our own emergency response box.

*Document each week that you are checking fire extinguisher and O2 to see if it is full and list A & B if there are more than one.

CHART REVIEW – USDB

PATIENT
How is commo from DPT and Health Clinic working?

Involvement in SJU gives us more visibility of patients from mental health and medical standpoint.

509 – patient has to be checked every ½ hour

Q: Do you feel comfortable with non-clinically trained personnel (i.e., guards, civilians) watching and assessing the patients in SHU?

PATIENT
Prescribed bland diet.

Who follows up to ensure this is happening?

Self-referral.

*CPT Hunter – credentials file.

*FINDING– when writing on back of page, must date and sign (big deal).

No date (no big deal) and printed name on back of sheet done by Dr. Johnson.

Need to put a title when sign (2LT LaCroix) USE STAMP!

Referred on 22 January 2004 to urologist.

Army policy on signatures being on referral results coming back in.

Sloppy since no one referred to referral after is came back in. RE: referral to a civilian urologist.

Insulin Dependent Patient:

PATIENT

Who manages medication? Dr. Edison and 2LT LaCroix

1 Mar - Insulin Dependent
10 Feb – Non-insulin dependent

Dr. Edison typed in wrong code. Coding and terminology did not match provider's diagnosis.

1. Systems approach to electronic and handwritten

2. Sloppy on dating/signatures.

Red entries in records are a no go.

CHALLENGE: What are some practical things that you can do to ensure right information is in the right place to ensure quality of care? Reference merging of electronic and handwritten records.

Was there any mention of this in previous JCAHO surveys either here or at other locations?

Summary

Provide great care, great facility, sharp people, know their limits, commo is great, patient is at center of care.

Quality of care outstanding and facility outstanding.

Recommendations:

Medical Record thing

Computer diagnosis does not match real diagnosis

Picked tough cases and got through them well

Munson Army Health Center
Fort Leavenworth, KS 66027
14 Apr 04
Behavioral Health Care JCAHO Survey

Surveyor: Mr Mims **Scribe: CPT Lara**

Morning Session
Met with credentialing staff, Ms Cotton. Surveyor asked if the organization had a policy for defining competency. Ms Cotton answered yes and explained that the organization is currently implementing a new for credentialing that has come down from MEDCOM. Ms McLilly and CPT Atkinson were also present for this.

Surveyor then asked if the organization was aware of the shift by the behavior health community of having fewer privileged providers and more scope of responsibility providers. Answer was no and then he wanted Ms Cotton to discuss how credentialing and privileges work in this organization. Ms Cotton showed surveyor SOP's, regulations, and the credentialing files for Lowery, Franks, Cleveland, and Sigmon. Surveyor was very impressed with the organizations paperwork and Ms Cotton's expertise and knowledge of the credentialing process.

Surveyor then wanted to know how organization measures competency. Staff explained how this was done through credentialing, counseling, performance evaluations, etc. Surveyor was very impressed with this.

Surveyor then wanted to know if CMH had direct say in who is hired. Ms McLilly explained to him that MEDCOM is the final authority of who is hired.

Surveyor looked at job descriptions of all staff members in CMH. Ms McLilly talked surveyor through a performance evaluation of a staff member in CMH. Surveyor asked if there were peer reviews done. Answer was yes.

Staff explained how clinical based guidelines are being incorporated into CMH.

Surveyor then explained that the credentialing process was excellent and that the privileges process was one of the best he has seen and that Ms Cotton does an outstanding job. He went on to inform the organization that based on JCAHO and behavioral health community guidelines that only hospital(inpatient) and long term care facilities need to have privileges. Outpatient CMH does not need to have privileges from the organization. This organization only has to give scope of responsibility. This is very important legally as privilege constitutes much, much more than scope of responsibility. Only one person or two really have to be privilege by the organization. Wanted to let the organization know this as it can help the organization out tremendously if the term privilege is not used, but instead scope of responsibility.

Surveyor then said he had no other recommendations for credentialing.

Dr Edison came over from the specialty clinic and demonstrated how CHCS works. Surveyor was impressed with the system, but would like for the organization to move towards doing all computer charting or all hard copy charting.

Surveyor also recommended that Dr Edison sign the treatment care plan and review and also that he serves on the CRC team.

Surveyor asked CPT Atkinson if CMH was cross walking the abbreviations used by them through the organization. CPT Atkinson answered yes and showed the memo that was submitted through the command for approval to use abbreviations dated 4 Apr 04. Surveyor was very impressed by this and said CMH is moving in the right direction and is doing a good job.

Surveyor went over a chart with CPT Atkinson. (Both psych and social work records were looked.) Surveyor liked the charting, but still wanted the organization to come up with an integrated plan of care.

Surveyor wanted all parts of the health care team to be one and to truly be an interdisciplinary team. He wanted medical as well as CMH to be one. SGT Hanson suggested that possibly a CMH staff member could be added to the PODS at Gentry to deal with CMH issues . Surveyor thought this would be an excellent idea and this is where JCAHO is going with behavior health. Surveyor suggested that all medical records be included with the CMH chart.

Surveyor gave some closing remarks to CMH staff. Said charting was very solid by staff members, but go still be improved upon. Suggested that all staff members be trained on medical terminology. Stressed that staff in CMH are CMH are doing a good job and doing the right thing, but that there is always room for improvement. Stressed to staff that medical issues must not fall through the cracks.

Surveyor talked with Ms Williams about how she does her job as receptionist/secretary. Ms Williams explained to the surveyor how she schedules patients, how she handles patients on the phone, how she feels about her job. Surveyor was impressed with how she handles her job.

Surveyor concluded the session and went to lunch and then worked on his final report. Surveyor stated that he would have recommendations, but no areas for improvement.

Afternoon Sessions
No afternoon session was conducted as surveyor work on his report.

Staff Interviewed: Ms McLilly, CPT Atkinson, Dr Edison, Ms Cotton, Ms Williams, SGT Hanson.

Outside People Interviewed: None

Charts looked at: CMH(Psych & Social Work), See above notes.

DAY 2 Dr Dann and Mr Ludwig Afternoon 1530

Asked that several individuals be present to discuss how they interact and work with USDB patients: Physical Therapist, Nutritionist and Pharmacist.

Physical Therapy:

How do you get order from provider for physical therapy on a patient? – Provider will put an order in CHCS.
Who does evaluation of patient?
What levels of treatment do you have? PTA, technician ?? How do they compare to what we have on civilian side of the house?
Do you have protocol for what technicians can do?
How do you let provider know where or how a patient is doing with physical therapy?
How would you get treatment extended?
Where are inmates given physical therapy?
Asked about cleaning on equipment – hydroculator specifically. Wanted to know if it was problem that it was only used occasionally and cleaning schedule.

Nutrition:

Insulin dependent patient – How do you as a nutritionist treat this patient?
How do you get initial referral to see a patient from the USD?
How do you ensure they get the correct diet?
Can you control their diet?
Who follows how patient is doing and if diet needs to be adjusted?
Special counseling how is that done if needed?
If you are on vacation and someone needs to see a nutritionist, what happens?
Any other patients that need to be counseled regarding diets other than diabetic?
How do you follow?
Do you have input into general meals that are served at the USDB?
Is and H & P done on each new prisoner? Does each new prisoner get a nutrition evaluation?

Pharmacy:

Are there any scheduled medications over at the USDB?
Are there any type III & IV?
What about the nitroglycerin?
What if it is expired, how do you know it is expired?

Likes the way ER box is changed out.
Likes locks being used on boxes and the fact that both pharmacy and individual at DB check before putting lock on box.

DAY 2, 1400 MR. MIMS OUTBRIEF ON BEHAVIORAL HEALTH

Started with commenting on the quality of care being given in CMH was not an issue. However, he had a suggestion for the way documentation is put together and interpretation of data.

He said he was giving us no recommendations requiring report to central office at this point, in other words no type ones. He said that would depend on the two remaining surveyors and what they found during their survey process.

Global issue he addressed was the "medical record structure". He could not find evidence that each of the records had same information in the patient's record. He said we need to designate which record is primary record.

Abbreviations – Commented that do not use abbreviations expanded to all records not just medication annotated in records. He suggested we do a cross walk with approved and not approved abbreviations lists we have. He thought we had way too many abbreviations being used and did not think all of them were approved.

Three areas where he was going to give us what they use to refer to as supplemental (actually I counted four) all fell in area of Assessment of Care – and revolved around the "written integrated summary report". This is something we do – not required by JCAHO.

1) He said he was holding us to our own standard – requirement. This was not used consistently throughout the service. Problem list – what you base care on, what you address now and what you defer to later. All need to be addressed and documented in chart. Form we are using is a good foundation – just not implemented well.
2) Involve physician in final plan of care. He wanted a physician to sign off on all treatment plans. He said they appear to be participating in process but not all the time and not always documented.
3) Commented again that if we do not address all the problems annotated in the note, then we need to document why not in the progress note.
4) Standard treatment plan – thought we had way too many different treatment plans. He thought they should be standardized throughout CMH.

He felt the competency review was good. He found nothing wrong with credential files he thought they were great and that Edith did an excellent job. Found nothing wrong with them. Thought we might do a better job of describing skills. Thought we had too many individuals privileged. Suggested we do observation of skills and competency also.

Day 3 Opening Conference with Dr. Dann and Mr. Ludwig MK's Notes

Dr. Dann Comments:

He commented that he had an interesting day at Ricahrds-Gebaur Clinic (one of our outlying clinics) and would have liked to stay a little bit longer had time allowed.
No adverse observations noted at the clinic.

His overall observations have not changed much since yesterday. Authentication on Lab and X-ray results – he hopes to have questions answered today on briefing we are going to give him this am on CHCS order/entry.

Issue – lack of dosage concentration on overprint used by ASC/Post Op for standing orders. Although he realizes it was a typing error and was fixed on the spot, he still found it in all charts reviewed for Endo and Gen Surgery. At this point in time not sure how this will play out in final results it could be a supplemental or a recommendation.

Mr. Ludwig:

He spent most of his day at the United States Disciplinary Barracks. No recommendations made with regard to this outside clinic either. His patient tracers at the USDB Clinic led to Radiology, Nutrition, Physical Therapy, and Pharmacy when they got back to main facility. Very impressed with Radiology and questions he had about aprons they used over at USDB and how they tracked checks. Pharmacy also please with answers to questions regarding scheduled medications and whether they had any or not.
Physical Therapy – asked questions on they know they have patient at USDB to go see. Where do you see them and do actual physical therapy? How they ensure equipment is clean and in good shape? Impressed with Nutritionist and how she has input into not only overall food served to inmates, but also how she has input into special needs patients. He felt she did was very thorough and complete in her evaluations, care, and concern and monitoring of the patients and food served in USDB. He said he has inspected at least 20 prisons in recent years and that this was by far the best he has seen.

Issue – only one he has is what appears to be a pattern he is finding in medical records of incomplete signatures/missing, or identification of provider missing (i.e., writing on back of SF600 and no signature following, so not sure when provider added note.), date of event missing (i.e., comment written by lab result, but no signature, date or time). Not sure at this point if it will be supplemental or recommendation. Depends on tracers they do today.

He was very impressed with medical maintenance interview.
He asked questions about time of year – when beneficiaries are all leaving from CGSC at once and also when our providers all switch out during summer time frame – wanted to know if we have a plan in place to adjust for this shift in workload?

Final piece of morning was presentation on use of CHCS and MEDBASE. We had an internal medicine physician come down and demonstrate provider order/entry; how to review and sign off on results in system; how to order tests and or drugs in system; how to pull up medication history; how to pull diagnosis history, etc. Once they saw this demonstrated it answered a lot of questions that were popping up about availability of test results, diagnoses, etc.

Overall morning brief went very well. We did adjust schedule again. We moved infection control to this afternoon and they will do this and EOC separately instead of together. This will move up sessions tomorrow on leadership and competency. This means they will probably finish up before noon and be able to brief us outcomes of survey before noon.

DAY 3 15 April 2004 SURVEYOR: Dr. Dann

SCRIBE: Mrs. Sanborn

DIABETES CLINIC

1. While waiting for Dr. Edison and charts to be reviewed, Dr. Dann was shown the Diabetes Outcome Poster. Mrs. Robin Diviney then was introduced and explained a little more in detail the aspects of the poster. We were then joined by Dr. Edison and Mrs. (Dr.) Judy Brown. There was a great deal of discussion on the poster, survey results and what the routine is when a patient is seen in the Diabetes Clinic. Dr. Dann asked how this clinic compares with similar ones in other MTFs. Dr. Edison reported that, as far as he knows, there are no other MTFs that have a Diabetes Clinic. All metrics are at goal. This one is multidisciplinary and has everything in one place except for eye exams, which are scheduled as needed. **Per Dr. Dann, this was the best presentation of a CPG outcome that he has ever seen.** Dr. Brown also showed the surveyor the Insulin Card which is initiated for the patient and has the patient's information on his/her medications. This card came from monthly clinic staff meetings and was at their recommendation. This card can also be shown to pharmacy as needed. This card also helps with a patient safety goal since we consider Insulin to be a high alert medication.

2. Dr. Dann and Dr. Edison then reviewed one chart of a patient with Diabetes Type 1. Question was asked how the master problem list is updated and where is the diagnosis on the problem list. This had been explained earlier at a briefing, but was reiterated with a record right there. Patient has been started on Pump therapy and so this process was explained in detail. Also, the difference between Type 1 and Type 2 Diabetes was further explained. The second patient record was on a patient with Diabetes Type 2. Pt. Has been doing well with weight loss, but has been noted to have a slight gain and also elevated BP. After thorough review of the chart, discussion was held on what all will now be done with the patient as far as follow-up and BP checks, etc. since he will now be treated for HTN as well as diabetes. Both charts looked good. Diabetes forms are filled out every 3 months on diabetic patient.

3. Mrs. Diviney showed Dr. Dann the step by step process, reports and charts, that are done via downloading the glucometers on every diabetic patient. She was also asked what her background was as far as being competent to do her job. The approach that is being used in the Diabetes Clinic and downloading the glucometers optimizes the patient's care and their understanding of their disease.

SPECIALTY CLINIC

1. The surveyor then asked for a tour of the clinic, going step by step about what happens when a patient presents for an appointment. The various clinics that work out of the Specialty Clinic were also explained.

2. Mrs. Brandi Woodson, Receptionist, was asked what she does when the patient checks in. Also she was asked about a note on the desk that states that if the patient is on high blood

pressure medicine to tell the staff. Mrs. Woodson reported that she does ask the patients and they are requested to sit for 10-15 minutes prior to having their BP checked. She was also asked about the Advanced Directives brochure. Did she know the policy for these? She reported that not too many people ask and if they are interested, they take a brochure and she suggests they talk to their provider. She was then asked if she knew the facility policy on whether or not DNRs/Advanced Directives are honored at this facility. She did not, but Dr. Dann stated that he did not expect her to know it, but for her information they are not honored

3. The PE clinic was described. Question was asked where the patients were screened, did they walk into the area behind the desk? The answer was no, and they are screened in the two designated screening rooms that he was shown later.

4. The screening rooms were visited next. Question was asked what was done routinely in there. BP/HT/WT/T/P/RR. Asked if Biomed (medical maintenance) checks the scale, this was answered by the label on the scale (yes). Asked if there were any medications or sharps in the rooms. Answer was no, just the sharps container itself. Asked if waived testing was performed and the answer was yes, only guaic cards and wet preps. Certificate is available and provided by the laboratory.

5. EKG Clinic was checked. Description of procedures done in that clinic (EKGs, Holter Monitors and Treadmills) was given. When asked who does the testing, was told an LPN and that all LPN staff (plus the one RN) are CBO'd in this area. How is present during procedures. Only the EKG tech/LPN for all but the treadmills, then a provider (Dr. Edison) is present during the testing and patient is educated. How about emergencies during a treadmill, how would you handle it? There is a crash cart available just outside the EKG room, and 9-1-1 would be called.

6. Procedure room was inspected. What types of procedures are done here, where are the instruments cleaned, and is there any regulated medical waste? Answers were minors only, no sedation, strictly local; instruments are pre-cleaned and taken down to the OR for sterilization and packaging; and there is no regulated medical waste produced in the minor room.

7. The dirty utility room was next and question was asked as to why the microscope. This is for wet preps that the PA performs. Asked if Cidex is used, for what and how often is it checked? It's used only for anoscopes and the vaginal light used by the PA for vaginal exams/Paps. It is emptied every Friday and replaced with new Cidex. Dipstick testing is performed prior to placing any instrument in it and also on the bottle when it is opened to ensure that it is still good.

8. Was asked about the procedure is in case of a fire. Appropriate answers about escapes, closing doors, etc. was given.

9. Mrs. (Dr.) Judy Brown was asked about her training/education and what all she does. She reported she is the Coumadin Clinic manager, works with the Diabetes Clinic, P&T committee and also does the medications in a "Traveler's Clinic" for those personnel going on leave/vacation and who need education on medications and illnesses they may acquire. Asked if she interacts with the Pharmacy, which she does for everything EXCEPT dispensing. How does the Coumadin Clinic work? It is done primarily by referral from the providers. She prescribes

the dosage depending on the INR. Was asked to discuss Coumadin Clinic and Diabetes Clinic outcomes at the Medical Management brief in the afternoon.

PHARMACY

1. Escorted by CPT Dorsey and CPL Iacovone. Looked at the staff break room and asked if medications were stored in the refrigerator. This is for staff food only.

2. Door to inside of pharmacy is cyber locked like it should be. There were still medications to be put away as the delivery was late today.

3. In the supply support area question was raised as to look alike/sound alike meds as to how they are stored. They are kept on separate shelves. These are stored by generic name. Question was asked about the use of the laminar flow hood, with sample of Ancef who dilutes it if it is IV push or slow drip. Pharmacy must mix if it is a slow drip.

4. The refrigerator where biologicals are stored was checked. It has a temperature scale on the door listing what the allowable temperature range is, is checked daily, logged daily and has a temperature gauge inside the machine as well. It is on emergency power so that the generator would kick in if needed. Question was asked as to who is notified if power goes off at night. AOD desk will contact pharmacist and/or pharmacy tech on call.

5. Prepack (bubble wrap) machine used for DB inmate medications was demonstrated. Used for medications that inmates can NOT keep in their cell.

6. **Working area needs improvement, needs to be more efficient.**

7. HIPAA requirements are filled by both refill and new RX windows. Who can dispense refills? Tech can dispense them.

8. For new RXs there is the Q-Matic system in place, 2 IDs required, each RX is reviewed by a pharmacist and both he and the tech initial the medication before dispensing. Allergies and drug interactions show up in CHCS when patient is pulled up. What if the patient has an allergy or drug interaction but the provider still wants to put them on that medication, how is that handled? The provider will notate it in the comments portion of CHCS and the pharmacy is able to see the allergy/interaction when the patient comes to get their med. Patient is asked about any problems with the medication and if the pharmacy personnel still has a question about this before dispensing, the provider will be contacted.

9. Are the medication bays self diagnostic (where a bar code is run showing which patient/med, etc.)? No, it is not hooked up to CHCS at this point, but maybe in the future.

10. Controlled medication area was reviewed after being asked where it is. Area was shown and the names of those authorized were given. Is there a way to check how many times someone goes into the vault? There is a log with name/date/time etc. Storage area is closed & locked after each use. Possible future use of cyber locks was discussed.

IMMUNIZATION CLINIC

1. Spoke to SGT Morrow, SPC McClelland and CPT Saunders. Only people treated by this clinic are those needing allergy shots (via serum for each patient) and well babies (children). No AD personnel for deployment shots are done in this clinic- they are done by Preventive Medicine.

2. How are allergy meds (serum) ordered/prescribed? Ordered by civilian allergist, RX brought here, sent to WRAMC, returned here and given to the patient.

3. When a patient comes in for their shot how do you make sure it is the correct patient and correct medication? Patient is called by name and rank and then medication is looked at to make sure it is for the correct patient. There are so few allergy shots given that most patients are on a first name basis with the techs.

4. Can you keep track of compliance of children getting scheduled immunizations on time? No, that's the provider's responsibility and it is in CHCS, not immunization.

5. What do you have for emergency reactions? There is Epinephrine and Bendaryl which the techs can give in the immunization clinic, but the MD must order it. A Code is called or the nearest MD is grabbed if close by. Hydrocortisone cream is used for local reactions. Is any airway equipment kept in this room? No, the patient would be taken (either by gurney or by walking if feasible) to the "crash" room, Room 60. There is an ERB, O2 and EKG machine there. All but the EKG machine is portable. If a Code is called the equipment will be taken to the clinic room, if the patient is ambulatory they will go to Room 60.

INFECTION CONTROL

1. How do you prevent nosocomial infections? Prevent by teaching, use of goals (handwashing, environmental compliance, housekeeping).

2. How do you approach NPSG #7, reduce the risk of health care acquired infections? It is a QI indicator and one was the issue of alcohol based hand cleaner. The steps in determining which one to use was described and then the training in the use of it. Infection Control will evaluate and determine if it is working. What factors were used to determine what to use? Smell, feel, potential irritation, all via a tool/staff input. Is there latitude to change a decision on a product? This is standardized throughout the Army, but they do have a couple of others that could replace what we currently have if need be.

3. What kind of surveillance activities are performed routinely? All OR cases and minor procedures are evaluated for surgery site infections. This is then reported by service quarterly at the Infection Control meeting. Overall the metrics here are 0.36%. One recent incident was infection after podiatric surgery. Internal processes were looked at (described to the surveyor) and patient education both pre and post procedure was reinforced. So far, this quarter there have been NO infections from podiatric surgery.

4. What other areas might be involved in Infection Control, like the building, environment, etc? Evaluations/studies on such things as ventilation, air issue problems and construction/remodeling are all looked at and reported as needed.

5. How is the Infection Control program designed around the community re: endemic diseases? Our community is those on Fort Leavenworth and PM, IC and health nurses from downtown and the KC area are contacted to keep us in the loop.

6. Is there anything on post that is a problem or recurring? No, but a close eye is kept on this as it is very minimal, no TB cases last year, a couple of people who came here already being treated for TB. Tammy Schad reported that they are following/tracking SARS and flu. All AD must go through PM. What are the main things that people returning from deployments are returning with? By the time we see them they are already diagnosed and treated. There have been a couple of cases of Lichmaniasis in the last year. Also the International Officers & their families go through PM, and are generally healthy.

7. What are the requirements for reporting communicable diseases locally? They are reported to and by PM, and the lab notifies through CHCS, phone call to PM and the State of Kansas is notified.

8. What are some examples of how the IC program is implemented into the Indicator Monitoring system? The OR tracks full PPE usage and reported quarterly, patient safety is also reported quarterly. Clinics have an IC representative in each section who reports. Four inspections are done per year by the IC Nurse use the same tool the clinics use. The lab reports angiograms quarterly, as well as MRSA/MRSE reports. If the lab has an issue they bring it to the IC committee, with an example of the butterfly needles given and the corrective action taken. PM follows bloodborne pathogens for all of post. RBGC falls under MACH. Mrs. Flanagan goes there and to the DB for checks and training. What is the physician involvement? Besides those on the committee, they take information back to their sections.

9. Is the culture changing, particularly in the Army, is it difficult to get the providers to buy into the IC program? Mrs. Flanagan feels that they are more open to it.

10. Are surveillance activities targeted? Yes, only surgeries (total) due to the small amounts done here.

11. In surgery, do you handle multi-dose vials? The use of Epinephrine (for irrigation in Ortho cases) in the OR was discussed step by step as to how it is used.

12. Are safety needles being used? Overall, yes, pretty much, as well as safety scalpels in the clinics for minor procedures. Is anesthesia still using needles for aspiration of meds from vials? Yes as long as there is no patient contact.

13. What are the perceived vulnerabilities that might be possibilities of error?

a. The use of 30 ml vials of Epinephrine has been done as an FMEA.

b. OR temperatures were looked at (humidity/heat). Techs were looking at the temp, but not reporting it, just logging it in. It is now announced at morning report and reported to the Chief, Nurse of OR/CMS.

c. Needles were being found in the trash in the men's and women's bathrooms near the pharmacy. These were Insulin needles. After a study it was recommended & done to put Sharps containers securely on the walls for the purpose of collecting the needles. This has worked well with no more needles found in the trash.

d. Also, diabetic patients were bringing used needles in various containers to the lab. After study and discussion with the pharmacy, the pharmacy now issues Sharps containers to the diabetic patients who turn them in to the lab when full. The lab then disposes them.

14. Question was asked as to the requirements for Hepatitis B and TB in the Army. Health care standards are the same as CDC. Hepatitis B is only mandatory for those personnel with actual hands-on patient care. TB is given annually.

JCAHO Survey
Munson Army Health Center
Day Three – 15 April 2004

CPT Henderson's Notes

PATIENT – R, C
Meds Patient

SUGGESTION: Make one page explanation of hour CHCS, MEDBASE, and the paper medical record work together. Could also include DMCSS, etc.

Family Practice, Lab, Pharmacy, nutrition, bariatric surgeon

No signature on back of nutrition visit in records. Does say "Over→"

How long does a consult/order stay in the system before it drops out?

PATIENT – N, E
Patient with x-ray, physical therapy

*In restroom above middle of stall – bomb threat matrix

CREDENTIALING:

Who can put foot on pedal to activate fluore machine? Tech? DA? Someone who is licensed?

A: Part of privileges per Dr. Mathis.

RADIOLOGY:

Environment of Care – ceiling/wall buckling in – SSG Hester in office.

Liked statement of questions patients about meds, allergies, etc. for non-_____ rads.

LABORATORY:

Patient education – talk to person who explained to Mr. Reeves about how to do a fasting blood sugar.

Number of noncompliant blood sugar fasting patients have you looked at?

RECOMMENDATION: Look at last 100 and sere how many had to be turned away (94 of them were). Dr. Edison's for example. Re-educate provider. Direct effect on delay of care.

DUE OUT: Wants to see documentation on lab fire drill. Copy of lab monthly safety inspection.

CONSTRUCTIVE COMMENT: Need more that one spill kit and they need to be strategically located.

CONSTRUCTIVE COMMENT: MSDS Slips that are used in areas are posed in area so that if there is an issue the MSDS's are easy to locate and read.

SUMMARY: Lab did well. Mats are exceptionally clean

PHARMACY:

No sign in sheet/roster.

Vicodin 5mg – 12:50 report due.

MEDICATION TRACER
Judy Brown
Deb Hevel
CPT Dorsey

Look at most efficient use of space in pharmacy.

Commended on pharmacy commo and teamwork throughout the facility from actual pharmacy and internal medicine, and all over the hospital.

Lots of strengths – medication management program

Issues: space, technology, automation

No recommendations.

Basement
Upstairs
Gentry

Think about what if there were to be a catastrophe with the demolition of the old DB due to age, size, and location. And Bell Hall.

EOC WALK THROUGH

Unlocked container with dangerous instruments in public hallway near an elevator – major security/safety problem.

Fairly serious.

CONSTRUCTIVE COMMENT: May want to lock refrigerator with med material. May want to get rid of excess stuff in housekeeping storage room.

EMPHASIZED MANY TIMES: Put MSDSs on carts for materials the housekeepers use, etc, etc, etc, etc.

Dr. Melendez – U/S machine is med maintenance – what does he do if he needs it?

CONSTRUCTIVE COMMENT: Sign on door that read fire alarm system.

Penetrations in fire alarm room.

Need to look at signage system.

WILL NOT WRITE UP: Trash can overflowing in OR on third floor, getting ready to do a vasectomy

Specialty Clinic Procedure Room.

Six procedures in four days.

Specialty Clinic: Someone on staff should watch when the anaphertic (?) shock and emergency boxes in specialty clinic.

COMMENT: Never have a spray bottle on top of cabinet for safety purposes. Plastic hold down on exam table should be eliminated if not used.

Use diabetic poster as tri-fold teaching handout.

Life Safety Training

RECOMMENDATIONS: Cords in pharmacy, possibly care in basement, for the age of the facility it is in good shape.

Tomorrow 30-45 minutes mini-tour in Gentry

Would like to see the following Credential Folders:
- CPT Hunter
- CPT Saunders

Would like to see the following Six-Sided Competency Folders:
- Judy Brown
- Robin Diviney
- Rich Purkett

Mary Kay Powers
Front End Receptionist – someone who could be questioned
Brandi Woodson

Tab the following:
Licensure (evidence of)
Copy of current job description
Copy of most recent evaluation
Continuing education section

Compare job description to what they are doing and find the evaluation is based on job description.

Day 3 – Medication Management Tracer Dr Dann & Mr. Ludwig MK's Notes

We had majority of P & T Committee at this meeting.
First he asked that we explain the medication management process at this facility.

Then Dr. Dann asked our Pharm D to explain to Mr. Ludwig what she did in the Coumadin Clinic. She had talked with him about this earlier in the day when he was doing a diabetic tracer. He loves scenarios so he presented one: what if you have a patient with a really weird coumadin – you just got lab results back – what happens? Will he be able to see a doctor today? Or will he have to wait? Judy told him no, she would get with IM physician and he would see him or if needed would get him seen in network or ER if it was necessary.

Then they both asked questions about how we deal with medication management. One example was an AD soldier who is on chronic meds who is going to be deployed quickly. How do you make sure he stays on medicine? How do you ensure he has the medicines he needs when he gets there? If he is deployed a long time, how do you ensure he continues to get meds he needs?

Wanted to know if we have AD personnel who are on insulin? Do we deploy them? If to Iraq, how do you ensure he will have insulin and supplies he will need? Recent memo from DOD regarding limits on who can and cannot be deployed was brought to them.

They then asked questions and wanted staff to explain about procurement, administrative issues, and maintenance of medications.

Prime vendor was discussed and availability of medication. How quickly we could obtain. Wanted to know how formulary was established? How do you get emergency medications if you run out of medication? Do you have credit card you can go downtown and use to purchase? How quickly can we get them in? How do you get something not on formulary? Special Drug Requests were discussed. Are these discussed in P & T Committee.

Impressed with pharmacy tour and information patients get when picking up meds.

Asked about how we check medication errors. What type of errors do we track? How? What do we do with? Actual errors and near misses both tracked?
Challenge with rotation of students thru here – how does that affect pharmacy and special drugs requested?

Next they wanted to know how provider monitored patient for effects of medication? One of our providers answered this one – with lab work, question patients about side effects, look at adverse drug reactions, etc.

Wanted to know how we handle medication orders on CHCS?
Started talking about how systems are made of many functions. Then went on to ask us what we thought was our strongest area in medication? And what is our weakest area that we are looking into – that we might need to work on.

Then went to discussion on space issue in pharmacy area. We had already addressed this issue. The week before JCAHO a group came in to look at redesigning and making better use of space pharmacy does have.

Again stated they were both impressed with visit to pharmacy. Both had visited earlier in the day. They thought staff were very knowledgeable and did a great job.

DAY 3 16 April 2004 SUBJECT: Competency Assessment

1. What kind of processes are in place for those who are and who are not credentialed? There is a Credentials committee, JAG for advice (does not sit on the committee) for those credentialed. For those not credentialed there is competency training.

2. When a new physician (new to the Army) is assigned what is the process? This was detailed step by step starting with the Processing Center going all the way through checking the National Provider Data Base. There is a check list for all the items required.

3. How are licenses verified? Per regulation, the actual licensing board is contacted to get prime source verification. Since turn-around time is generally slow, phone calls are placed to speed up the process.

4. What about the provider who PCS's here from another MTF? Credentials files are maintained at the prior duty station, is forwarded to this MTF by certified mail. The file is then prepared, reviewed and presented to the Credentials Committee. License is verified also.

5. Does the Army recognize licenses from all 50 states? Yes. What about moonlighting? The provider has to get a license in the state they wish to moonlight in and must pay their own malpractice insurance. Those providers credentialed here can see our beneficiaries in the downtown civilian hospitals, as they are credentialed there as well and the Army covers the malpractice insurance. They are allowed to take care of patients otherwise only under the Good Samaritan care.

6. What about the contract providers? There are two types of these. Personal service is directly between the government and provider, malpractice carrier is the government and a credentials file is kept with prime source verification. The second type is Resource Sharing contracts (includes Spectrum). With this one they provide complete credentials files, it is between us and them, they decide on the provider, and they get their own malpractice coverage.

7. What about network providers? These fall under the laws of the state where they are practicing. We don't credential them.

8. Is the Commander like the CEO of a civilian hospital and does she sign off on all credentials? Yes.

9. Is there a difference in how personnel are oriented? All orientation is pretty much the same, but the length can vary depending on where the person is working and if they, for example, have or have not had experience with the computer systems such as CHCS.

10. Are PAs credentialed and privileged? Yes, just like all other providers.

11. If a surgeon, for example, comes here from another facility and he was doing more extensive surgery there, how are his credentials done? The actual privileges/credentials for what he can do is different/dependent on the facility.

12. Ms. Cotton reported that we are in the process of going from the old regulation to the new one which was effective 26 Mar 04. What are the basic differences? The Army is getting away from a long list of core privileges and the privileging process is changing. Credentials are now to be reviewed by the Credentials Committee, then the Executive Committee, and then the Commander reviews for final approval.

13. What happens if you are notified of a provider who is impaired somehow? The immediate supervisor is informed. The new regulation states that the Chief of the Service, DCCS and the Commander can put that provider in abeyance. The issues stays within the facility and there is a mechanism in place to take care of this. For non-credentialed personnel, such as medics, the call would be made by the Company Commander, if a nurse by the DCN. But, it all starts with the supervisor. There is an Impaired Provider Committee that meets as needed for items like this.

14. Credentials files and three 6-sided folders were reviewed and discussed.

Day 4 Opening Conference with Dr. Dann and Mr. Ludwig MK's Notes

Objective was to rehash daily briefings and information from Leadership on processes.

Dr Dann commented that he saw nothing new on third day of surveying. At this point he commented that he only had two findings. One would probably result in a recommendation for improvement and the other would probably be a supplemental. He said this would probably be it unless he found something else today during leadership or competency conferences.

Improvement – Typographical error found on overprint used in surgical clinic
Supplemental – using unapproved abbreviations not on either of our approved lists

Mr. Ludwig said his third day played out pretty much the same way. He was probably going to have one recommendation for improvement and one supplemental.

Improvement – Incomplete medical record
Supplemental – Cords in pharmacy that were hanging down

Leadership Conference

This was very informal and staff could pipe in with answers and did. We had a lot of participation from staff at all levels. The following are questions that were asked.

How does leadership determine and evaluate how effective you are in what you do?
Several people piped in on this one and talked about BSC, HA Patient Satisfaction Survey, GPRMC and MEDCOM electronic surveys, Compliments and Complaints,
IG Sensing sessions, CO2 training, etc.

They noticed suggestion boxes throughout the facility. How are suggestion boxes being used?
Patient Representative got up and talked about this one and the process we use.

Because of turmoil the world is in today – how have you as leadership been practive in those being deployed? How do you help them get ready and their families?

Scenario – lets say you need to bring soldier in your office today and tell him has to go to Iraq – he is going to be deployed. How long will he go for? How quickly can you deploy someone?

Asked SGM directly about process he uses for gaging & understanding how morale is in the enlisted soldiers?

How does a junior enlisted become a senior enlisted?

Asked staff what the biggest challenge was to keep this place running?

Asked the Commander is she got sick or was deployed who would replace her? How would they be oriented to position if it happened quickly?

What is biggest challenge for medical staff?

They both commented that this was a great session. I think what happened was that staff anticipated most of their questions and asked before they could ask.

JCAHO Survey
Munson Army Health Center
Day Four – 16 April 2004

CPT Henderson's Notes

SUGGESTION:

No pencil entries in six-side competency folders unless governed by a regulation. Would not comply with civilian sector guidelines.

Remove plastic strips on exam tables if not using them.

RMW – meets standard but infectious waste could be created in patient exam room. You should have a single red bag to use to carry waste to RMW container. Put it in same place in every room.

No emergency power, but have ballasts. Need temporary evacuation lights. Use Chem-Lights taped to the back of every door.

A "Surveyor" may ask to prove that the glass on Dr. Ganacias door is shatter proof.

DAY 3 16 April 2004 SUBJECT: Competency Assessment

1. What kind of processes are in place for those who are and who are not credentialed? There is a Credentials committee, JAG for advice (does not sit on the committee) for those credentialed. For those not credentialed there is competency training.

2. When a new physician (new to the Army) is assigned what is the process? This was detailed step by step starting with the Processing Center going all the way through checking the National Provider Data Base. There is a check list for all the items required.

3. How are licenses verified? Per regulation, the actual licensing board is contacted to get prime source verification. Since turn-around time is generally slow, phone calls are placed to speed up the process.

4. What about the provider who PCS's here from another MTF? Credentials files are maintained at the prior duty station, is forwarded to this MTF by certified mail. The file is then prepared, reviewed and presented to the Credentials Committee. License is verified also.

5. Does the Army recognize licenses from all 50 states? Yes. What about moonlighting? The provider has to get a license in the state they wish to moonlight in and must pay their own malpractice insurance. Those providers credentialed here can see our beneficiaries in the downtown civilian hospitals, as they are credentialed there as well and the Army covers the malpractice insurance. They are allowed to take care of patients otherwise only under the Good Samaritan care.

6. What about the contract providers? There are two types of these. Personal service is directly between the government and provider, malpractice carrier is the government and a credentials file is kept with prime source verification. The second type is Resource Sharing contracts (includes Spectrum). With this one they provide complete credentials files, it is between us and them, they decide on the provider, and they get their own malpractice coverage.

7. What about network providers? These fall under the laws of the state where they are practicing. We don't credential them.

8. Is the Commander like the CEO of a civilian hospital and does she sign off on all credentials? Yes.

9. Is there a difference in how personnel are oriented? All orientation is pretty much the same, but the length can vary depending on where the person is working and if they, for example, have or have not had experience with the computer systems such as CHCS.

10. Are PAs credentialed and privileged? Yes, just like all other providers.

11. If a surgeon, for example, comes here from another facility and he was doing more extensive surgery there, how are his credentials done? The actual privileges/credentials for what he can do is different/dependent on the facility.

12. Ms. Cotton reported that we are in the process of going from the old regulation to the new one which was effective 26 Mar 04. What are the basic differences? The Army is getting away from a long list of core privileges and the privileging process is changing. Credentials are now to be reviewed by the Credentials Committee, then the Executive Committee, and then the Commander reviews for final approval.

13. What happens if you are notified of a provider who is impaired somehow? The immediate supervisor is informed. The new regulation states that the Chief of the Service, DCCS and the Commander can put that provider in abeyance. The issues stays within the facility and there is a mechanism in place to take care of this. For non-credentialed personnel, such as medics, the call would be made by the Company Commander, if a nurse by the DCN. But, it all starts with the supervisor. There is an Impaired Provider Committee that meets as needed for items like this.

14. Credentials files and three 6-sided folders were reviewed and discussed.

FINAL OUTBRIEF WITH SURVEYORS 11:30 16 Apr 04

No surprises in final out brief with surveyors.

Mr. Mims, BHC surveyor briefed us at end of second day and us with two supplemental.

Dr. Dann and Mr. Ludwig had one recommendation and one supplemental each.

Recommendations:

Std IM.6.10 – AHC – The organization has a complete and accurate medical record for every patient assessed or treated.
E.P. 4 – Every medical record entry is dated, the author identified and, when necessary according to law or regulation and organization policy, is authenticated.

In the review of multiple medical records signatures and identification of providers were missing. In addition when signatures were present dates of the signatures were missing.

Std MM.3.20 – AHC – Medication orders are written clearly and transcribed accurately.
E.P. 8 – In addition, the organization reviews and updates preprinted order sheets as needed.

It was noted that in printed standard orders in the surgical suite, the dosages (concentrations) of two drugs was not indicated. For example: Versed 10 IV, and KCL 20, i.e. no milligrams or milli equivalents evident. This was a typographical error on the forms that had not been noticed and the forms had been in use for an indeterminate period of time. New, corrected forms were produced during the survey.

Supplemental:

PC.4.40 – BHC – The organization develops a plan for care, treatment, and services that reflects the assessed needs, strengths, and limitations.
E.P. 1 – The plan of care, treatment and services includes the following:
Clearly defined problems and needs statements
Measurable goals and objectives based on the assessed needs, strengths, and the client's limitations
The frequency of care, treatment, and services
A description of facilitating factors and possible barriers to care, treatment, and services or reaching goals.
The client's needs are identified based on information from the assessment.

Not all medical problems noted in the primary medical records were included in the behavioral health comprehensive treatment plans nor was there documentation of reasons for decisions not to address all identified problems on the problem list.

PC.5.60 – BHC – The organization coordinates the care, treatment, and services provided to a client as part of the plan for care, treatment, and services and consistent with the organization's scope of care, treatment, and services.
E.P. 1 – The organization coordinates the care, treatment, and services provided through internal resources to a client.

Documented evidence of the role and responsibility of the physicians in treatment team processes specifically in prioritization of care decisions and approval of recommendations for treatment strategies and outcomes was inconsistent in the two tracers conducted in behavioral health services.

IM.3.10 – AHC – The organization has processes in place to effectively managed information, including the capturing, reporting, processing, storing, retrieving, disseminating, and displaying of clinical/service and nonclinical data and information.
E.P.2 – Abbreviations, acronyms, and symbols are standardized throughout the organization and there is a list of abbreviations, acronyms, and symbols not to use.

The list of abbreviations, acronyms and symbols not to use was in compliance with JCAHO requirements and was being expanded. There was an approved list available, but it was noted in several medical records that abbreviations were being used by caregivers that not on this list.

EC.8.10 – AHC – The organization establishes and maintains an appropriate environment.
E.P. 4 – Areas used by the patients are safe, clean, functional, and comfortable.

In the Pharmacy Area multiple electrical cords and extension cords were hanging from the ceiling thus creating a serious safety hazard.

Surveyors said they were very impressed with the staff. Everyone was very helpful and seemed to go out of their way to assist surveyors with the new process and were willing to adjust their schedules in order to talk with them. They both said how impressed they were with our staff. Said we should be very proud that there were no findings having to do with quality of care we our giving our patients. Both surveyors commented that they would definitely bring their families to our facility to receive care and that this was really saying something. They apparently do not always say this to facilities they are surveying and we should be proud of this.